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CHALENG 2005 Survey: VA Alaska HCS & RO - 463

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 450

2. Estimated Number of Veterans who are Chronically Homeless: 225

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 450 (estimated number of homeless veterans in service area) **x chronically homeless rate (50 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	360	0
Transitional Housing Beds	30	0
Permanent Housing Beds	150	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Eye Care	Evaluate and address eligibility issues for homeless veterans who are not currently eligible. Contact LensCrafters as possible second option beyond existing collaboration with COSTCO for eye care.
Glasses	Explore possibility of expanding eligibility for homeless veterans who are not presently eligible for glasses. Contact Lions Club and LensCrafters to explore possibility of eye care service. Ensure that eye care is listed as specific service available.
Long-term, permanent housing	Initiate referrals to two newly established long-term transitional housing programs. Continue to advocate with housing authority for appeals with individuals with criminal history.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **23 Non-VA staff Participants: 52.4%**
Homeless/Formerly Homeless: **34.8%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.52	4.0%	3.47
Food	4.13	4.0%	3.80
Clothing	4.04	.0%	3.61
Emergency (immediate) shelter	4.09	9.0%	3.33
Halfway house or transitional living facility	3.19	17.0%	3.07
Long-term, permanent housing	2.95	57.0%	2.49
Detoxification from substances	3.39	17.0%	3.41
Treatment for substance abuse	3.78	26.0%	3.55
Services for emotional or psychiatric problems	3.5	22.0%	3.46
Treatment for dual diagnosis	3.0	13.0%	3.30
Family counseling	2.79	4.0%	2.99
Medical services	4.04	4.0%	3.78
Women's health care	3.21	4.0%	3.23
Help with medication	3.52	13.0%	3.46
Drop-in center or day program	2.50	4.0%	2.98
AIDS/HIV testing/counseling	3.77	.0%	3.51
TB testing	3.83	.0%	3.71
TB treatment	3.71	.0%	3.57
Hepatitis C testing	3.57	.0%	3.63
Dental care	2.61	17.0%	2.59
Eye care	3.09	4.0%	2.88
Glasses	3.04	.0%	2.88
VA disability/pension	3.18	4.0%	3.40
Welfare payments	2.95	.0%	3.03
SSI/SSD process	3.00	4.0%	3.10
Guardianship (financial)	2.71	9.0%	2.85
Help managing money	2.78	.0%	2.87
Job training	2.95	9.0%	3.02
Help with finding a job or getting employment	3.18	4.0%	3.14
Help getting needed documents or identification	3.43	.0%	3.28
Help with transportation	2.96	9.0%	3.02
Education	2.59	4.0%	3.00
Child care	2.16	.0%	2.45
Legal assistance	3.00	4.0%	2.71
Discharge upgrade	3.00	.0%	3.00
Spiritual	3.77	13.0%	3.36
Re-entry services for incarcerated veterans	2.55	9.0%	2.72
Elder Healthcare	3.20	4.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.00
Co-location of Services - Services from the VA and your agency provided in one location.	2.80
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.40
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.40
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.50
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.30
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.78
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.60
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.60
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.22
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.22
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.50

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.82
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.55

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CHALENG 2005 Survey: VA DOM White City, OR - 692

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 350

2. Estimated Number of Veterans who are Chronically Homeless: 109

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 350 (estimated number of homeless veterans in service area) **x chronically homeless rate (31 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	95	50
Transitional Housing Beds	110	100
Permanent Housing Beds	420	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 10

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Pursue Per Diem Grant to increase bed capacity.
Immediate shelter	Pursue shelter bed increase.
Long-term, permanent housing	Pursue continued funding for Home-at-Last scattered leasing program.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **19** **Non-VA staff Participants: 84.2%**
Homeless/Formerly Homeless: **10.5%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.05	.0%	3.47
Food	3.47	.0%	3.80
Clothing	3.24	.0%	3.61
Emergency (immediate) shelter	2.63	76.0%	3.33
Halfway house or transitional living facility	2.37	78.0%	3.07
Long-term, permanent housing	1.58	83.0%	2.49
Detoxification from substances	2.42	6.0%	3.41
Treatment for substance abuse	2.89	.0%	3.55
Services for emotional or psychiatric problems	2.8	6.0%	3.46
Treatment for dual diagnosis	2.5	.0%	3.30
Family counseling	2.28	6.0%	2.99
Medical services	2.83	6.0%	3.78
Women's health care	2.28	6.0%	3.23
Help with medication	2.33	11.0%	3.46
Drop-in center or day program	2.11	.0%	2.98
AIDS/HIV testing/counseling	2.63	.0%	3.51
TB testing	3.00	.0%	3.71
TB treatment	2.83	.0%	3.57
Hepatitis C testing	2.72	.0%	3.63
Dental care	1.33	6.0%	2.59
Eye care	1.89	6.0%	2.88
Glasses	1.94	.0%	2.88
VA disability/pension	3.53	.0%	3.40
Welfare payments	2.28	.0%	3.03
SSI/SSD process	3.18	.0%	3.10
Guardianship (financial)	1.94	.0%	2.85
Help managing money	2.06	.0%	2.87
Job training	2.67	.0%	3.02
Help with finding a job or getting employment	3.00	.0%	3.14
Help getting needed documents or identification	2.22	.0%	3.28
Help with transportation	2.11	.0%	3.02
Education	2.53	.0%	3.00
Child care	1.44	6.0%	2.45
Legal assistance	1.74	12.0%	2.71
Discharge upgrade	2.56	.0%	3.00
Spiritual	2.32	6.0%	3.36
Re-entry services for incarcerated veterans	1.84	.0%	2.72
Elder Healthcare	2.06	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.40
Co-location of Services - Services from the VA and your agency provided in one location.	1.50
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.93
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.20
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.27
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.69
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.81
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.73
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.75
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.38
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.69
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.56

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.75
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.75

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CHALENG 2005 Survey: VA Puget Sound HCS (VAMC American Lake - 663A4 and VAMC Seattle, WA - 663), Tacoma, WA

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 2670

2. Estimated Number of Veterans who are Chronically Homeless: 1121

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 2670 (estimated number of homeless veterans in service area) **x chronically homeless rate (42 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	229	150
Transitional Housing Beds	225	125
Permanent Housing Beds	14	400

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 26

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue with local, state, and federal agencies to lobby for additional support for Section 8 housing vouchers. Continue to work with local consortiums to fight for priority status for veterans.
Transitional living facility or halfway house	A newly hired GPD liaison will focus on increase networking with nonprofits in the community to encourage GPD applications. Continue our work with homeless providers in community on continuum of care issues.
Help finding a job or getting employment	Newly funded Supported Employment program will be offering assistance with community work placement for veterans with serious mental illness. VAPSHCS has been successful at obtaining authorization from VISN to backfill some vacant staff positions.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **34** **Non-VA staff Participants: 93.5%**
Homeless/Formerly Homeless: **14.7%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	2.82	.0%	3.47
Food	3.48	3.0%	3.80
Clothing	3.18	.0%	3.61
Emergency (immediate) shelter	2.76	13.0%	3.33
Halfway house or transitional living facility	1.94	47.0%	3.07
Long-term, permanent housing	1.88	65.0%	2.49
Detoxification from substances	2.88	7.0%	3.41
Treatment for substance abuse	2.78	13.0%	3.55
Services for emotional or psychiatric problems	2.5	17.0%	3.46
Treatment for dual diagnosis	2.4	10.0%	3.30
Family counseling	2.40	.0%	2.99
Medical services	2.94	10.0%	3.78
Women's health care	2.80	3.0%	3.23
Help with medication	2.63	10.0%	3.46
Drop-in center or day program	2.66	3.0%	2.98
AIDS/HIV testing/counseling	2.69	.0%	3.51
TB testing	2.75	.0%	3.71
TB treatment	2.63	.0%	3.57
Hepatitis C testing	2.59	.0%	3.63
Dental care	2.12	13.0%	2.59
Eye care	2.18	.0%	2.88
Glasses	2.24	3.0%	2.88
VA disability/pension	2.70	13.0%	3.40
Welfare payments	2.48	3.0%	3.03
SSI/SSD process	2.31	7.0%	3.10
Guardianship (financial)	2.48	.0%	2.85
Help managing money	2.24	.0%	2.87
Job training	2.45	13.0%	3.02
Help with finding a job or getting employment	2.33	23.0%	3.14
Help getting needed documents or identification	2.76	.0%	3.28
Help with transportation	2.42	10.0%	3.02
Education	2.45	.0%	3.00
Child care	2.18	.0%	2.45
Legal assistance	2.27	3.0%	2.71
Discharge upgrade	2.41	.0%	3.00
Spiritual	2.82	.0%	3.36
Re-entry services for incarcerated veterans	2.18	7.0%	2.72
Elder Healthcare	2.38	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.96
Co-location of Services - Services from the VA and your agency provided in one location.	1.85
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.68
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.73
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.12
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.46
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.36
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.60
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.46
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.31
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.36
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.62

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	2.74
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	2.72

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CHALENG 2005 Survey: VA Roseburg HCS, OR - 653 (Eugene, OR)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 4800

2. Estimated Number of Veterans who are Chronically Homeless: 1824

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 4800 (estimated number of homeless veterans in service area) **x chronically homeless rate (38 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	450	300
Transitional Housing Beds	302	250
Permanent Housing Beds	110	150

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 14

3. CHALENG Point of Contact Action Plan for FY 2005

Dental care	Now that we have established Per Diem and placement by referral to local community partner, will attempt to better access VA dental program. Additionally, will work with development of resources to fund local care with low income clinic for walk-in care
Long-term, permanent housing	We have maintained 25 HUD-VASH vouchers in this community through good relationships with HALSA. We are forming new alliances in the community with transitional housing that my lead to long-term housing.
Transitional living facility or halfway house	Continue to support Community Outreach Inc. Per Diem program. Continue to pursue Per Diem grant in coordination with St. Vincent DePaul We have newly secured 5 "Vet Lift" apartments that are funded by grants received by St. Vincent DePaul through HUD.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **21** **Non-VA staff Participants: 66.7%**
Homeless/Formerly Homeless: **47.6%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.75	.0%	3.47
Food	3.85	.0%	3.80
Clothing	3.72	.0%	3.61
Emergency (immediate) shelter	2.60	21.0%	3.33
Halfway house or transitional living facility	2.80	16.0%	3.07
Long-term, permanent housing	2.55	26.0%	2.49
Detoxification from substances	3.16	11.0%	3.41
Treatment for substance abuse	3.32	5.0%	3.55
Services for emotional or psychiatric problems	3.5	.0%	3.46
Treatment for dual diagnosis	3.5	.0%	3.30
Family counseling	3.00	16.0%	2.99
Medical services	3.45	11.0%	3.78
Women's health care	3.35	.0%	3.23
Help with medication	3.47	.0%	3.46
Drop-in center or day program	3.32	5.0%	2.98
AIDS/HIV testing/counseling	3.72	.0%	3.51
TB testing	3.79	.0%	3.71
TB treatment	3.63	.0%	3.57
Hepatitis C testing	3.89	5.0%	3.63
Dental care	2.20	47.0%	2.59
Eye care	2.70	.0%	2.88
Glasses	2.42	5.0%	2.88
VA disability/pension	3.00	11.0%	3.40
Welfare payments	2.89	5.0%	3.03
SSI/SSD process	3.00	16.0%	3.10
Guardianship (financial)	2.68	.0%	2.85
Help managing money	2.68	5.0%	2.87
Job training	2.74	5.0%	3.02
Help with finding a job or getting employment	3.15	5.0%	3.14
Help getting needed documents or identification	3.10	5.0%	3.28
Help with transportation	2.79	16.0%	3.02
Education	2.84	10.0%	3.00
Child care	2.79	11.0%	2.45
Legal assistance	2.53	5.0%	2.71
Discharge upgrade	3.00	11.0%	3.00
Spiritual	3.73	10.0%	3.36
Re-entry services for incarcerated veterans	3.00	.0%	2.72
Elder Healthcare	3.39	11.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.83
Co-location of Services - Services from the VA and your agency provided in one location.	1.83
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.09
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.25
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.75
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.92
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.27
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.42
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.17
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.92
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.75
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.00

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.82
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.45

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Boise, ID - 531

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 350

2. Estimated Number of Veterans who are Chronically Homeless: 56

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 350 (estimated number of homeless veterans in service area) **x chronically homeless rate (16 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	50	0
Transitional Housing Beds	30	20
Permanent Housing Beds	10	10

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue working with local coalition and mayor's task force to establish long-term and permanent housing. Currently having meetings with city and other regarding Grant and Per Diem and other housing funding.
Immediate shelter	Meetings with local Rescue Mission are ongoing, especially about improving access for veterans.
Dental care	Working with local dentists who will work on sliding-scale basis. Local service organizations are pooling resources to assist with care that exceeds emergency care.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **8** **Non-VA staff Participants: 75.0%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.25	.0%	3.47
Food	4.13	38.0%	3.80
Clothing	4.00	25.0%	3.61
Emergency (immediate) shelter	2.88	63.0%	3.33
Halfway house or transitional living facility	2.63	25.0%	3.07
Long-term, permanent housing	2.25	50.0%	2.49
Detoxification from substances	3.88	.0%	3.41
Treatment for substance abuse	4.13	.0%	3.55
Services for emotional or psychiatric problems	4.0	.0%	3.46
Treatment for dual diagnosis	4.0	.0%	3.30
Family counseling	3.63	.0%	2.99
Medical services	4.13	.0%	3.78
Women's health care	3.75	.0%	3.23
Help with medication	4.00	.0%	3.46
Drop-in center or day program	3.63	.0%	2.98
AIDS/HIV testing/counseling	3.75	.0%	3.51
TB testing	3.38	.0%	3.71
TB treatment	3.75	.0%	3.57
Hepatitis C testing	4.00	.0%	3.63
Dental care	1.88	38.0%	2.59
Eye care	2.50	.0%	2.88
Glasses	2.38	.0%	2.88
VA disability/pension	3.25	13.0%	3.40
Welfare payments	2.63	.0%	3.03
SSI/SSD process	2.50	13.0%	3.10
Guardianship (financial)	2.75	.0%	2.85
Help managing money	2.75	.0%	2.87
Job training	2.50	.0%	3.02
Help with finding a job or getting employment	3.75	13.0%	3.14
Help getting needed documents or identification	4.00	.0%	3.28
Help with transportation	3.25	13.0%	3.02
Education	2.88	.0%	3.00
Child care	2.75	.0%	2.45
Legal assistance	2.25	.0%	2.71
Discharge upgrade	3.25	13.0%	3.00
Spiritual	3.13	.0%	3.36
Re-entry services for incarcerated veterans	3.50	.0%	2.72
Elder Healthcare	3.88	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.67
Co-location of Services - Services from the VA and your agency provided in one location.	2.33
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	3.17
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.00
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.67
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.33
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.50
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.50
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.83
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.00
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.33

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.67
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.67

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Portland, OR - 648

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1790

2. Estimated Number of Veterans who are Chronically Homeless: 555

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1790 (estimated number of homeless veterans in service area) **x chronically homeless rate (31 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	120	130
Transitional Housing Beds	253	0
Permanent Housing Beds	70	15

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Family Counseling	New Outcomes for Homeless will help facilitate access for family counseling
Transportation	Emphasize methods to acquire bus tickets -- needs verified by staff.
Childcare	Discuss this perceived need with HCHV staff to determine how many veterans are affected.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **17 Non-VA staff Participants: 71.4%**
Homeless/Formerly Homeless: **17.6%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.88	.0%	3.47
Food	4.50	12.0%	3.80
Clothing	3.81	.0%	3.61
Emergency (immediate) shelter	3.00	18.0%	3.33
Halfway house or transitional living facility	2.94	18.0%	3.07
Long-term, permanent housing	2.80	59.0%	2.49
Detoxification from substances	3.81	12.0%	3.41
Treatment for substance abuse	3.81	12.0%	3.55
Services for emotional or psychiatric problems	3.2	6.0%	3.46
Treatment for dual diagnosis	2.9	6.0%	3.30
Family counseling	2.57	.0%	2.99
Medical services	3.40	24.0%	3.78
Women's health care	3.31	.0%	3.23
Help with medication	3.31	6.0%	3.46
Drop-in center or day program	2.57	6.0%	2.98
AIDS/HIV testing/counseling	3.46	.0%	3.51
TB testing	4.07	.0%	3.71
TB treatment	3.53	.0%	3.57
Hepatitis C testing	3.67	.0%	3.63
Dental care	2.27	24.0%	2.59
Eye care	2.80	6.0%	2.88
Glasses	3.00	.0%	2.88
VA disability/pension	3.31	6.0%	3.40
Welfare payments	3.46	.0%	3.03
SSI/SSD process	3.07	.0%	3.10
Guardianship (financial)	2.71	.0%	2.85
Help managing money	2.73	6.0%	2.87
Job training	3.06	12.0%	3.02
Help with finding a job or getting employment	3.50	35.0%	3.14
Help getting needed documents or identification	3.20	.0%	3.28
Help with transportation	2.87	6.0%	3.02
Education	2.69	.0%	3.00
Child care	2.07	.0%	2.45
Legal assistance	2.50	6.0%	2.71
Discharge upgrade	3.14	.0%	3.00
Spiritual	3.44	.0%	3.36
Re-entry services for incarcerated veterans	2.63	18.0%	2.72
Elder Healthcare	2.81	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.80
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.90
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.90
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.80
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.90
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.40
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.40
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.80
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.78
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.60

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.30
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.60

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Spokane, WA - 668

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 3600

2. Estimated Number of Veterans who are Chronically Homeless: 1224

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 3600 (estimated number of homeless veterans in service area) **x chronically homeless rate (34 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	590	50
Transitional Housing Beds	40	10
Permanent Housing Beds	3	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 10

3. CHALENG Point of Contact Action Plan for FY 2005

Dental care	46% of respondents selected dental care as the #1 unmet need. Will try to get funding to shift treatment to community resources. Had some limited success with acute care and treatment in FY 2005. The resources
Help getting needed documents or identification	Due to changes in public law, it is now much more difficult to obtain documents needed for I.D. In some cases (e.g., check cashing), six pieces of ID are needed. Will work more with on-line resources to expedite access to birth certificates.
Long-term, permanent housing	We have seven veterans in long-term housing. Grants will be brought on-line for FY 05-06.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **41** **Non-VA staff Participants: 77.5%**
Homeless/Formerly Homeless: **56.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	4.54	3.0%	3.47
Food	4.51	5.0%	3.80
Clothing	4.34	8.0%	3.61
Emergency (immediate) shelter	3.93	18.0%	3.33
Halfway house or transitional living facility	4.15	18.0%	3.07
Long-term, permanent housing	3.82	23.0%	2.49
Detoxification from substances	3.75	3.0%	3.41
Treatment for substance abuse	3.95	5.0%	3.55
Services for emotional or psychiatric problems	4.1	10.0%	3.46
Treatment for dual diagnosis	3.6	3.0%	3.30
Family counseling	3.05	10.0%	2.99
Medical services	4.37	13.0%	3.78
Women's health care	3.06	8.0%	3.23
Help with medication	4.07	3.0%	3.46
Drop-in center or day program	2.79	18.0%	2.98
AIDS/HIV testing/counseling	3.77	.0%	3.51
TB testing	3.88	.0%	3.71
TB treatment	3.83	.0%	3.57
Hepatitis C testing	3.85	.0%	3.63
Dental care	2.35	40.0%	2.59
Eye care	4.05	.0%	2.88
Glasses	4.08	3.0%	2.88
VA disability/pension	4.26	8.0%	3.40
Welfare payments	3.89	3.0%	3.03
SSI/SSD process	3.55	5.0%	3.10
Guardianship (financial)	3.24	.0%	2.85
Help managing money	3.54	.0%	2.87
Job training	3.29	18.0%	3.02
Help with finding a job or getting employment	3.49	3.0%	3.14
Help getting needed documents or identification	3.03	25.0%	3.28
Help with transportation	3.85	3.0%	3.02
Education	3.22	12.0%	3.00
Child care	2.51	10.0%	2.45
Legal assistance	2.55	18.0%	2.71
Discharge upgrade	3.38	3.0%	3.00
Spiritual	3.63	.0%	3.36
Re-entry services for incarcerated veterans	2.89	10.0%	2.72
Elder Healthcare	3.14	3.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.53
Co-location of Services - Services from the VA and your agency provided in one location.	2.63
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	3.32
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.84
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.95
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.44
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	3.06
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	3.28
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.94
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.22
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.56
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.56

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.42
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.60

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VAMC Walla Walla, WA - 687

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 297

2. Estimated Number of Veterans who are Chronically Homeless: 89

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 297 (estimated number of homeless veterans in service area) **x chronically homeless rate (30 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	37	0
Transitional Housing Beds	20	14
Permanent Housing Beds	20	20

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Explore possibility of applying for VA Grant and Per Diem and Department of Labor Homeless Veterans Reintegration funding.
Immediate shelter	Explore creation of emergency shelter in Yakima and identify existing resources.
Long-term, permanent housing	Contact local housing authority to see if process for obtaining Section 8 housing can be shortened. Explore application to CTED for permanent supportive housing from Housing Trust Fund.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **8** **Non-VA staff Participants: 42.9%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.25	.0%	3.47
Food	3.29	14.0%	3.80
Clothing	3.57	.0%	3.61
Emergency (immediate) shelter	3.13	71.0%	3.33
Halfway house or transitional living facility	3.71	14.0%	3.07
Long-term, permanent housing	2.50	29.0%	2.49
Detoxification from substances	3.57	14.0%	3.41
Treatment for substance abuse	3.13	14.0%	3.55
Services for emotional or psychiatric problems	3.1	14.0%	3.46
Treatment for dual diagnosis	3.1	.0%	3.30
Family counseling	2.63	.0%	2.99
Medical services	3.71	43.0%	3.78
Women's health care	2.75	29.0%	3.23
Help with medication	2.63	.0%	3.46
Drop-in center or day program	3.14	.0%	2.98
AIDS/HIV testing/counseling	2.29	14.0%	3.51
TB testing	2.43	.0%	3.71
TB treatment	2.43	.0%	3.57
Hepatitis C testing	2.50	.0%	3.63
Dental care	2.29	14.0%	2.59
Eye care	2.00	.0%	2.88
Glasses	2.00	.0%	2.88
VA disability/pension	3.29	.0%	3.40
Welfare payments	2.33	.0%	3.03
SSI/SSD process	2.86	.0%	3.10
Guardianship (financial)	2.50	.0%	2.85
Help managing money	2.67	.0%	2.87
Job training	2.17	.0%	3.02
Help with finding a job or getting employment	2.88	.0%	3.14
Help getting needed documents or identification	3.25	14.0%	3.28
Help with transportation	3.13	.0%	3.02
Education	2.14	.0%	3.00
Child care	2.00	.0%	2.45
Legal assistance	2.25	.0%	2.71
Discharge upgrade	3.14	.0%	3.00
Spiritual	2.75	.0%	3.36
Re-entry services for incarcerated veterans	2.43	14.0%	2.72
Elder Healthcare	2.43	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.67
Co-location of Services - Services from the VA and your agency provided in one location.	2.00
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.00
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.33
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.67
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.00
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.67
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.00
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.00
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.00

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.00
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.33